House of Representatives

General Assembly

File No. 183

January Session, 2011

Substitute House Bill No. 6360

House of Representatives, March 23, 2011

The Committee on Human Services reported through REP. TERCYAK of the 26th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES OF A DECISION TO DENY PAYMENT FOR A PRESCRIPTION DRUG UNDER THE MEDICAID PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-274 of the general statutes is amended by adding subsections (e) and (f) as follows (*Effective October 1, 2011*):

(NEW) (e) The Commissioner of Social Services or any independent pharmacy consultant acting on behalf of the Department of Social Services shall provide written notice to a Medicaid recipient whenever the commissioner or such consultant electronically denies payment, in whole or in part, for a prescribed drug. The commissioner or such consultant shall provide such notice to the Medicaid recipient at the time the recipient is at the pharmacy to obtain the drug or shall give notice by regular or electronic mail to the Medicaid recipient not later than twenty-four hours after the commissioner or such consultant denies payment for the drug. Such notice shall be individually tailored to describe the circumstances under which the commissioner or such

consultant denied payment for the drug prescribed to the Medicaid recipient and shall: (1) Identify the drug for which payment was denied; (2) explain the reason for the denial of full or partial payment; (3) state the regulatory basis for the denial; (4) describe the process to request a hearing to review the denial; and (5) describe additional actions, if any, that the Medicaid recipient may take to obtain a supply of the drug for which payment was denied or a supply of a substitute drug.

(NEW) (f) The Commissioner of Social Services or independent pharmacy consultant acting on behalf of the Department of Social Services shall notify, in writing by regular or electronic mail, the medical practitioner who issued the prescription for the drug for which payment was denied not later than two business days after the denial to advise the practitioner of such denial and whether the denial was due to the practitioner's failure to obtain prior authorization for the drug. If such denial was due to the practitioner's failure to obtain prior authorization for the drug, the commissioner or such consultant shall explain to the practitioner the need to obtain prior authorization in accordance with the provisions of subsection (c) of this section and shall provide the practitioner with the names of equally effective drugs that do not require prior authorization. If the practitioner fails to submit a request for prior authorization for the drug originally prescribed for the Medicaid recipient and an equally effective drug not requiring prior authorization is not dispensed to the Medicaid recipient within twelve calendar days from the date of the commissioner's or such consultant's initial denial, the commissioner or such consultant shall contact the practitioner to again notify the practitioner of the practitioner's ability to submit a request for prior authorization for the drug originally prescribed or to prescribe an equally effective drug not requiring prior authorization.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2011*	17b-274

Statement of Legislative Commissioners:
In section 1(f), the phrase "subsection (e) of this section" was replaced with "subsection (c) of this section" for accuracy.

HS *Joint Favorable Subst.-LCO*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 12 $	FY 13 $
Social Services, Dept.	GF - Potential Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill could result in a cost to the Department of Social Services (DSS) associated with notifying Medicaid recipients and physicians of prescription denials.

The cost to the state depends on how the bill's requirements are implemented. Under current practice, the pharmacist receives a message via the point-of-sale system indicating why payment has been denied. Modifying this system to provide a written notice specific to the recipient may be necessary to meet the bill's requirements. The cost of modification is unknown at this time. Based on 2008-2009 data, 5,142 claims were denied electronically at the pharmacy, after the individual had already received a temporary supply of medication, due to the need for prior authorization.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 6360

AN ACT CONCERNING NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES OF A DECISION TO DENY PAYMENT FOR A PRESCRIPTION DRUG UNDER THE MEDICAID PROGRAM.

SUMMARY:

This bill requires the Department of Social Services (DSS) commissioner, or a pharmacy consultant acting on his behalf, to provide written notice to Medicaid recipients when the department or consultant denies electronic payment, either wholly or partially. The notice must be (1) provided at the pharmacy at the time the recipient is there to pick up the prescription or (2) mailed (electronically or regular mail) to the recipient within 24 hours once payment for the prescription is denied.

The bill also requires the commissioner or consultant to notify the prescribing medical practitioner, in writing by regular or electronic mail, within two days of the denial. The notice must indicate whether the denial is due to the practitioner's failure to obtain prior authorization (PA) from the department or the consultant.

If the denial is due to a failure to obtain PA, the bill requires the commissioner or consultant to explain the need for PA and provide names of alternative drugs that can be prescribed. The bill also requires further notification if the practitioner fails to request PA or prescribe an alternative drug.

EFFECTIVE DATE: October 1, 2011

NOTICE TO RECIPIENTS

The bill requires the DSS commissioner, or any independent pharmacy consultant acting on DSS' behalf (DSS currently contracts

with Hewlett Packard), to provide written notice to a Medicaid recipient whenever DSS or the consultant electronically denies payment to the pharmacy for a prescribed drug, either in whole or partially. DSS must provide the notice when the recipient is at the pharmacy or within 24 hours from the time payment was denied. The notice must:

1. be individually tailored to describe the reasons why payment was denied;
2. identify the drug for which payment was denied;
3. state the regulatory basis for the denial;
4. describe the process for requesting a hearing to review the denial; and
5. describe additional actions, if any, that the recipient may take to obtain the full amount of drugs prescribed or a supply of a substitute drug.

Under current law, DSS can deny payment and require PA for most drugs covered under any medical assistance program it administers, including Medicaid. When PA is required and the pharmacist cannot obtain the prescriber's authorization at the time the medical assistance recipient presents the prescription to be filled, the pharmacist must dispense a one-time, 14-day supply of the requested drug.

The law requires DSS to process PA requests within two hours of receiving them and if DSS does not grant or deny the PA within two hours of receiving it, PA is deemed granted. PA for brand-name drugs is valid for one year from the date the prescription is filled.

NOTICE TO PRESCRIBING PRACTITIONER

The bill requires the DSS commissioner or the pharmacy consultant to also notify the prescribing practitioner when payment is denied. The notice must (1) be in writing and sent either electronically or through regular mail no later than two business days after the denial and (2)

indicate whether the denial was due to the practitioner's failure to obtain PA.

EXPLANATION OF NEED FOR PA

If the denial was due to a failure to obtain PA, the bill requires the commissioner or the consultant to explain to the practitioner the need to obtain PA and provide the name of "equally effective" drugs that do not require PA.

If the practitioner fails to submit a PA request and the pharmacist does not dispense an equally effective drug that does not require PA within 12 calendar days from the initial payment denial, the commissioner or pharmacy consultant must contact the prescriber again, indicating the provider's ability to request PA or prescribe an equally effective alternative not requiring PA.

BACKGROUND

Prior Authorization (PA)

In practice, DSS' pharmacy consultant, Hewlett Packard, requests PA from a prescriber when a medical practitioner has prescribed (1) a brand-name drug when a chemically equivalent generic is available; (2) an early refill; (3) a drug that is not on DSS' preferred drug list; or (4) a medication which exceeds the optimal, instead of preferred, dosage. When this occurs, the point-of-sale system at the pharmacy will return a message to the pharmacist indicating why payment has been denied.

DSS Provider Bulletin

A June 2010 DSS Provider Bulletin, sent to all pharmacists participating in DSS medical assistance programs, includes a statement urging medical providers to be "proactive" in switching DSS clients to drugs on DSS' preferred drug list when appropriate or in obtaining PA. It states that if a claim for a non-preferred drug is submitted and no PA is on file (with DSS or its consultant), the pharmacy receives a message that the claim is denied for the drug and that it can contact the prescribing doctor to initiate PA with Hewlett Packard.

Request for Declaratory Ruling

In October 2010, Connecticut Legal Aid petitioned DSS (and the Office of Healthcare Advocate filed a petition to intervene) on behalf of a Medicaid enrollee for a declaratory ruling as to whether DSS must provide notice in the situations described above. The petitioners claim that federal law and state regulation require written notice of denial within 24 hours of the time payment is denied for a Medicaid patient's prescription. DSS has until next month to issue its ruling, which is subject to appeal to the Superior Court.

COMMITTEE ACTION

Human Services Committee

Joint Favorable
Yea 18 Nay 0 (03/10/2011)